DOCUMENT RESUME

ED 148 562 **SE 022 921**

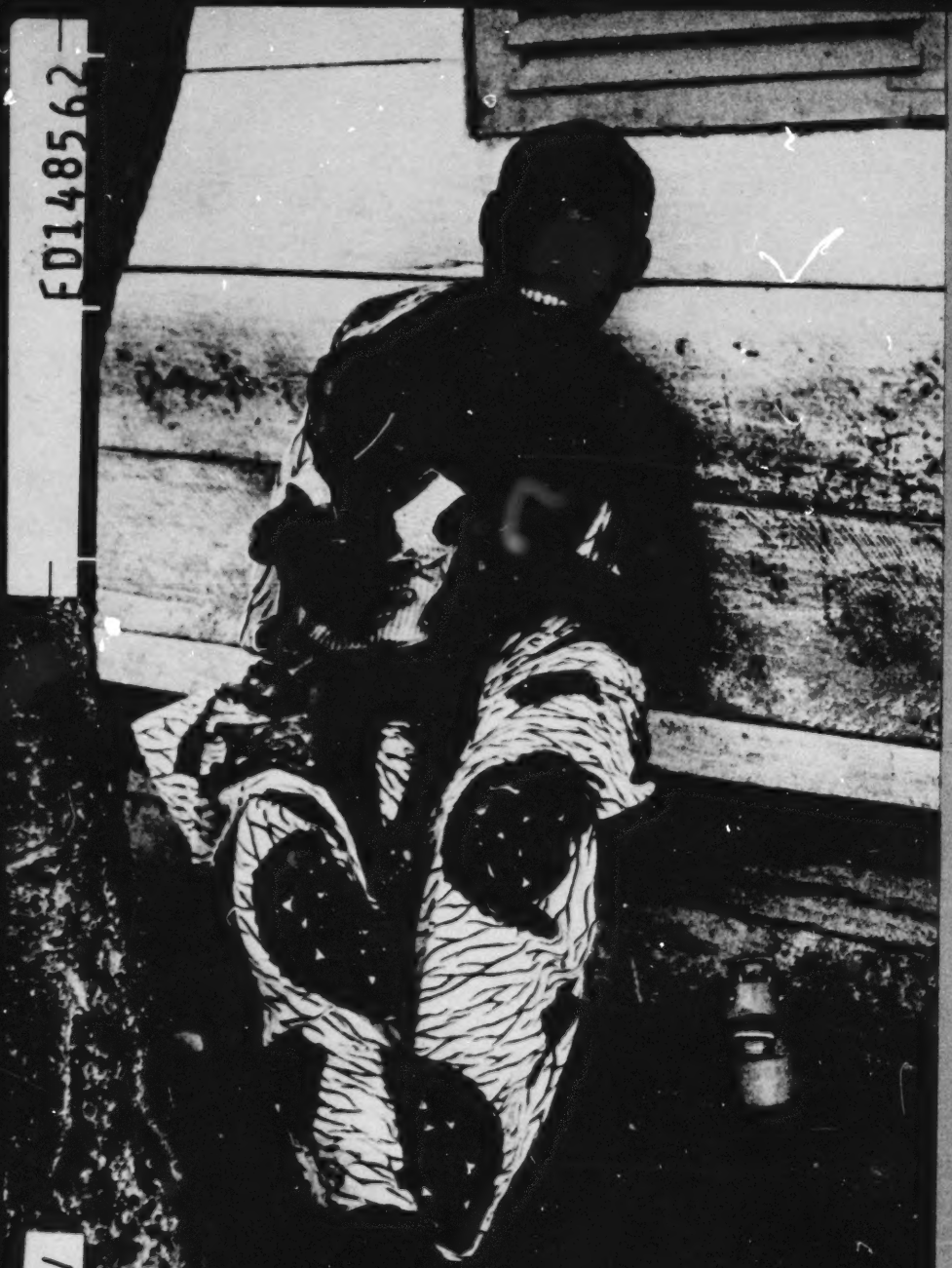
AUTHOR	Piotrow, Phyllis T., Ed.
TITLE	Successful Family Planning Programs. Draper World Population Fund Report, No. 4, Summer 1977.
INSTITUTION	Draper World Population Fund, Washington, D.C.; Population Crisis Committee, Washington, D.C.
PUB DATE	77
NOTE	33p.; Photographs may not reproduce well
EDRS PRICE	MF-$0.83 HC-$2.06 Plus Postage.
DESCRIPTORS	*Birth Rate; *Contraception; Demography; Environment; *Family Planning; International Education; *Population Education; *Population Trends; Reproduction (Biology); World Problems

ABSTRACT

This publication describes successful family planning programs throughout the world. Discussed in detail are programs in Colombia, Mauritius, Maharashtra, the People's Republic of China, Sri Lanka, and the United States. Photographs illustrate the articles and, in some cases, family planning vital statistics are given. The Draper World Population Fund, which publishes this report, works closely with the International Planned Parenthood Federation (IPPF) and the Population Crisis Committee (PCC). (MA)

****
* Documents acquired by ERIC include many informal unpublished *
* materials not available from other sources. ERIC makes every effort *
* to obtain the best copy available. Nevertheless, items of marginal *
* reproducibility are often encountered and this affects the quality *
* of the microfiche and hardcopy reproductions ERIC makes available *
* via the ERIC Document Reproduction Service (EDRS). EDRS is not *
* responsible for the quality of the original document. Reproductions *
* supplied by EDRS are the best that can be made from the original. *
****

ED148562



DRAPER WORLD POPULATION FUND REPORT

NO. 4
SUMMER
1977

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Phyllis Piotrow

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM."

Successful Family Planning Programs

SE 022 921

William H. Draper, Jr.
1894-1974

THE DRAPER WORLD POPULATION FUND

The Draper World Population Fund was established in honor of the late William H. Draper, Jr. to encourage and expand those activities which promise the greatest impact in slowing world population growth. Contributions to the Fund go to the two private organizations with which Draper worked most closely—the International Planned Parenthood Federation (IPPF) and the Population Crisis Committee (PCC).

The goal of the Draper World Population Fund is to raise more than ten million dollars over the next five years. Two earlier Funds established by Draper—the Victor Fund in 1965, and the Victor-Bostrom Fund in 1968—together contributed more than ten million dollars to the IPPF. The new Draper Fund advances and gives continuity to Draper's pioneering efforts. It permits concerned individuals, corporations and foundations to join in making a significant contribution to a cause of major international importance. During 1975 and 1976, the Population Crisis Committee/Draper World Population Fund raised approximately $2.8 million.

Although in the long run governments must mobilize the resources needed to solve national population problems, IPPF through its worldwide network of member organizations represents the vital and constructive force of the private sector in influencing how soon and how soundly governments move. In both IPPF and PCC, volunteers and professionals work together to demonstrate new approaches and to build public support for the programs that are needed. As William H. Draper, Jr. often pointed out, contributions to such organizations can "do more good, dollar for dollar, than any similar amount employed in any other way."

Mrs. Angier Biddle Duke

William S. Gaud
Co-Chairmen
Draper World Population Fund

The Draper World Population Fund Report

1120 Nineteenth Street, N.W., Washington, D.C. 20036

Editor: Phyllis T. Piotrow

Challenging Established Wisdom in Colombia 3
by Fernando Tamayo, M.D.

Family Planning in Mauritius 8
by V. Rajcoomar

Family Planning Progress in Maharashtra 12
by Tara Kanitkar and J.R. Rele

Reductions in the Crude Birth Rate in Selected Developing Countries: 1955-1974 16

Chinese Birth Planning: What Makes It Work? 18
by Pi-chao Chen

Family Planning Helps in Sri Lanka 23
by Dr. (Miss) Siva Chinnatamby

Impact of US Family Planning Programs 26
by Frederick S. Jaffe

Making Family Planning Work 30

Photographs courtesy of Bernard Cole, the Food and Agriculture Organization, Paul Harrison, Planned Parenthood-World Population, the United Nation's Childrens Emergency Fund, and the Agency for International Development.

Library of Congress Catalog Card Number: 77-84421

Innovative family planning programs reduce birthrates

Challenging Established Wisdom in Colombia

Fernando Tamayo, M.D.
President, Asociación Pro-Bienestar de la Familia Colombiana (Profamilia)
President, International Planned Parenthood Federation

ONE of the surprising things about the family planning movement was that it first appeared on the scene, at least in Latin America, already equipped with complete knowledge, already certain what would work and what would not. It did not matter that the principles of this established wisdom were untested and unproved. They were regarded as axiomatic by almost all the family planning associations affiliated with the International Planned Parenthood Federation (IPPF), which first introduced family planning to Latin America in the 1960s. This established wisdom was based on the following precepts:

(1) Family planning is a very sensitive and controversial activity. It should be carried out quietly so as to avoid public controversy and to deny its opponents a focus for attack.

(2) Massive publicity should be avoided, especially the use of mass media. Besides, word of mouth is the best medium; there is no substitute for personal contact.

(3) Family planning services should be delivered under strict medical supervision. Women accepting the most advanced methods (pills, IUDs) should first be given a thorough physical examination and should be called back for physical checkups at regular intervals thereafter—all to be given by a medical doctor.

(4) It follows from the last point that only a family planning medical clinic can provide family planning services to people who cannot pay for private medicine—in other words, to those who are most in need.

Such convictions, so universally held, cannot simply be derided. For in certain situations and at certain times—notably when the movement was just beginning—they may even have had a certain validity. Consider the third point in particular: that family planning services should be provided only under strict medical supervision. The inauguration of family planning in Latin America happened to coincide with a number of worldwide attacks on the safety of the pill and the IUD. It was undoubtedly necessary to demonstrate that the use of such advanced methods helped improve the health of potential mothers. Even in retrospect it is hard to see how such a demonstration could have been made except under medical supervision. However, once the demonstration was made, the principle of strict medical control probably outlived its usefulness.

The Association for the Well-being of the Colombian Family (Profamilia) was organized in 1965 when the birthrate of the country stood at 44 per thousand. **By 1976, the Colombian birthrate had declined to 31 per thousand, bringing the national growth rate down from over 3.4 percent per year to between 2.2 percent and 2.4 percent.** Many reasons could be given for this remarkable drop in natality, including changing attitudes and increasing urbanization and education. There was no outright opposition from the government of Colombia, which, though sometimes lukewarm in its support of family planning programs, did go so far as to organize some activities in official facilities. Some family planning activities have also been carried out by the Colombian Association of Medical School Faculties (ASCOFAME).

Role of Profamilia

At the same time, it would be only fair to say that a good part of the credit should be assigned to Profamilia, the only organization in the country to maintain a vigorous and sustained family planning campaign—one that

has achieved broad coverage of the Colombian population. **It is significant to note that Profamilia's success was possible only as a result of abandoning or sharply modifying the four "principles of established wisdom" once so widely used as infallible guides.**

The first principle on the need to work quietly could probably never have been applied in Colombia, sometimes called "the most Catholic of Catholic countries," because the institutional opposition within the Church hierarchy was always very alert to anything it perceived as a violation of doctrine. Showing little apparent sympathy to those Catholic theologians who assert the prior claims of individual conscience, the Colombian church repeatedly attacked Profamilia in both the Catholic and the public press. Although these attacks removed any possibility of "working quietly," they had some beneficial effects from Profamilia's point of view. **They gave widespread publicity to the work of the Association, and they mobilized Colombia's intellectual community on the side of family planning.**

Because it proved impossible to abide by the first principle of established wisdom, Profamilia then decided to abandon the second principle—avoiding publicity. Thus, Profamilia deliberately organized the first mass media campaign in South America to promote family planning. By 1968 an effort was under way to blanket the country with short messages on family planning, which were broadcast over 40 radio stations. The messages directed potential acceptors to attend the nearest family planning clinic. By then Profamilia had organized clinics in all of Colombia's important cities. Evaluations subsequently established that the radio campaign had a powerful effect on clinic attendance.

Profamilia does not deny the value of word-of-mouth contacts. Rather, the personal approach is seen as a valuable adjunct to mass media campaigns. But it is too expensive to rely on word of mouth and personal contacts only to the exclusion of other information techniques.

Profamilia also helped pioneer the postpartum approach in Latin American hospitals to reach women who have just given birth. Thanks to the interest and cooperation shown in official circles, the Association was able to install a postpartum program in Bogota's largest Social Security hospital. This program has attained acceptance rates of around 30 percent of all the women who enter this large facility as patients. Yet the postpartum approach is also a delivery system confined to strict medical control.

Using Nonmedical Channels

By the end of the 1960s, it had become evident that the physical examination given to potential acceptors of orals was not adequate in predicting which women would experience side effects. At the same time it had become clear that the practice of family planning, under whatever conditions, led to a remarkable improvement in maternal and child health. These findings opened the way to systems

of nonclinical contraceptive distribution where paramedical or community-based workers distributed oral contraceptives.

With financial assistance from the Colombian Federation of Coffee Growers, who had determined to improve health indices in the coffee growing areas of the country, Profamilia became the first organization in Latin America to undertake nonclinical distribution programs. The work began in 1970 in the State of Risaralda where distribution posts, manned by Profamilia-trained personnel, were established throughout a rural area that was considered very difficult for family planning programs to reach. The response was overwhelming. **It clearly showed that when delivery systems are not confined to the classical clinic, many barriers to the use of family planning can be eliminated. Within three years, half of the women at risk in the district served by the community-based distribution program had become acceptors of contraception. Even more surprising were the continuation rates. According to a Population Council evaluation, 80 percent of acceptors remained as users after one year.**

These results were so heartening that the community-based distribution program was extended to nine other states, including the most populous, thanks largely to continued support from the Coffee Growers Federation. It was quickly seen that the same system could be applied to the marginal, low-income districts of the major cities. In 1974 community-based distribution was brought to a poor neighborhood in Bogota. Again, acceptance and continuation rates were excellent. Community-based distribution has since been extended to poor districts in all of Colombia's most important cities.

While it has been shown that prior physical examination has little value in predicting complications, some acceptors of orals still experience side effects. These women are referred to the nearest clinic by local distributors, who have been trained to make such referrals. Accordingly, the clinic has assumed a new role, not as the center of the delivery system, but rather as an essential backup to the far-flung community-based distribution systems. Thus, the new system has not impelled Profamilia to dismantle its clinical network, which in 1976 consisted of 48 centers located throughout Colombia's major population centers. Indeed, the combination of clinics and community-based distribution places 70 percent of the nation's people within easy reach of Profamilia's facilities. These two nongovernmental systems are, in fact, now serving 15 percent of all the women at risk in the country.

If clinics are no longer at the center of Profamilia's activities, that role might still be assigned to one clinic, the *Centro Piloto* (pilot center) in Bogota, which also houses Profamilia's administrative headquarters. The *Centro Piloto* performs many functions including a large amount of training, but it remains primarily a center for the delivery of family planning services. In 1976, the

center handled a total of 100,000 visits from new and continuing acceptors, thus becoming possibly the busiest single family planning center in the entire developing world.

Commercial Distribution

Based on the *Centro Piloto*, another novel program has been developed which involves the commercial distribution of contraceptives. Commercial distribution is, of course, another delivery system that evades strict medical control. Under this program, Profamilia imports contraceptives, condoms and pills and distributes them widely to pharmacies and other retail outlets at a price high enough to make the program self-sustaining and low enough to keep the prices of all brands down to a reasonable level. By this means, more than 800,000 cycles of pills and 2,300,000 units of condoms were distributed in 1976. The system also includes some distribution of foams and jellies.

Obviously, family planning services with the wide coverage provided by Profamilia are an important drain on the limited financial resources of the International Planned Parenthood Federation, which is, after all, a private organization supported by voluntary contributions. For this reason, Profamilia organized a vigorous campaign to raise funds locally—something that is not easy in a country on the road to development. Nonetheless, the response has been gratifying, as exemplified by the considerable support given to the work of the association by the Federation of Coffee Growers. Many donations are in a form other than cash, as for example the free air time provided by Colombia's three largest radio networks. Donations in kind and in cash, supplemented by grants that the association has been able to obtain from other organizations, have meant that for the past few years IPPF has been called on to supply less than half of Profamilia's annual budget.

Pioneer Voluntary Sterilization Program

Profamilia is convinced that sterilization, freely chosen, is an essential adjunct to contraceptive programs. It represents a choice that should be offered to couples who have all the children they wish to have and who prefer a surgical method, for example, to continued pill-taking for the rest of a woman's fertile life. Yet Profamilia was informed, on the basis of established wisdom, that sterilization programs would be impossible to establish in a Catholic environment; that the publicity resulting from such programs would be extremely harmful; and that they could even result in the Association's being closed down. It was also said that the *macho* attitude allegedly so prevalent in Latin American men would prevent them from seeking the comparatively simple procedure known as vasectomy. These statements were made with great conviction, despite the fact that sterilization programs had never been attempted in Latin America.

In 1973 Profamilia decided to test the atmosphere surrounding sterilization in a limited program set up in the *Centro Piloto*. The response was overwhelming and, in fact, required a doubling and then a redoubling of the facilities available in the *Centro Piloto*. The program was soon extended to other cities, tapping what was obviously an unfulfilled demand on the part of many Latin American women for this safe and simple procedure. The established wisdom was shown to be, in fact, a libel on the intelligence of people in Spanish America. In 1976, 18,044 women chose to be sterilized through the new simplified procedures at present available in Profamilia while 776 men were vasectomized.

Family Planning Succeeds

Profamilia's experience demonstrates that a vigorous family planning program can succeed in reducing excessive rates of population growth on a national scale. It is probably true that a multiplier effect has been at work to reduce the birthrate 13 points in only 12 years as such a reduction would require a coverage greater than the 15 percent of women at risk now served by Profamilia. Some of the decline can be attributed to the continued widespread practice of clandestine abortion. Some of the decline has undoubtedly come from the legitimization of family planning practices that has accompanied Profamilia's wide media coverage. The media coverage has created an immense amount of discussion of the subject with the result that people everywhere in Colombia have come to feel that family size is a matter subject to decision. While the most marginal elements in the population will always need assistance, there is probably a threshold of acceptance beyond which the practice of family planning by informed individuals becomes virtually self-sustaining, program or no program.

With its very low death rate (9 per thousand in 1976), Colombia is still growing too fast for a country seeking to advance its economic and social development. The in-

credible growth rate of the cities—as high as 7 percent per year for Bogota—continues to present almost insuperable problems. Although Profamilia has helped family planning "take hold" in Colombia, a rapid expansion of information and services would be most desirable right now to speed the achievement of a more reasonable equilibrium between population growth and the growth of the country's economic capabilities. **A family planning program appropriate to the size of the nation can probably be achieved only with active and more vigorous participation by the national government. Such participation may not be too far off now that Profamilia has succeeded in demonstrating, that the people of Colombia wish to control the size of their families and that there are few political pitfalls in helping them do so.**

A further comment: Profamilia's 2,400 rural and urban distribution posts that serve the community-based distribution program mean that there are 2,400 active proponents of family planning working in every setting the country has to offer—rural countryside, hamlets, small towns and big cities.

Family planning is now entering its second decade as an organized activity in Latin America. The movement has encountered great problems there, but at the same time it has achieved unexpected successes—and not only in Colombia. Family planning must still be regarded as an essentially new and novel activity in the Latin American environment, and thus even more effective techniques for the delivery of information and services will undoubtedly be developed. **The Colombian experience indicates that a questioning and innovative attitude is called for if programs are to achieve wide coverage, especially for those people who are most in need of what family planning has to offer. As with any new activity, a skeptical attitude should be taken toward "established wisdom" if the movement is to succeed.**

Contraceptives, free of charge and available to everyone

Family Planning in Mauritius

V. Rajcoomar
Demographer
in collaboration with
Director of Family Planning,
Maternal and Child Health Services

THE tiny island of Mauritius (720 sq. miles) in the Indian Ocean off the coast of Africa experienced a sudden increase in population size during the period immediately following World War II. At the time of the 1944 census, the population of Mauritius was 419,135, increasing by about 1.5 percent annually. The 1952 census recorded a population of 501,515, increasing by more than 2 percent annually. The rapid increase in population became even sharper between 1952 and 1962 when an annual average rate of more than 3 percent was recorded. At such a fast rate, the size of the population would more than double to about 1.3 million by 1985.

In 1976, the population in Mauritius was estimated at 867,885, making Mauritius one of the most densely populated countries in the world with more than 1,200 persons per square mile.

The causes of this demographic change are not difficult to identify. Before 1945 the crude birthrate averaged 36 per 1,000, and the crude death rate was 28.5 per thousand, giving an annual growth rate of less than 1 percent per year. Infant mortality rates fluctuated around 154 per thousand. A systematic campaign for the eradication of malaria, which was started in 1948, promptly caused a very sharp fall in mortality. This, coupled with the prevailing high fertility, quickly swelled the size of the population. The crude death rate fell from 27.1 per thousand in 1944 to 15.8 per thousand in 1954, a decline of almost 50 percent. The first evidence of this rapid population growth came in the 1952 census. Faced then with the dual problems of underdevelopment and a fast growing population, in 1953 the government appointed a committee "to consider the problem presented by the trend of increase of population in relation to the economic resources and potential productivity of the country and to investigate and report on the practicability of any method of resolving the problem." In its 1955 report, the committee stressed the need to make family planning services available to the population.

Private Agency Active

In 1957 a voluntary organization, the Mauritius Family Planning Association (MFPA), was formed to stimulate public awareness of the need for planned parenthood. From its inception, the MFPA has advocated all available methods of contraception. An intensive family planning motivational campaign has been sustained by employed personnel as well as by volunteers in the association.

In 1963 a second, largely Catholic, organization, the Action Familiale (AF), was formed to encourage use of the rhythm method of contraception. In 1964 the government offered financial support to both the MFPA and the AF, and in 1965 the International Planned Parenthood Federation (IPPF) started supplying a yearly grant as well as supplies to the MFPA.

The population policy enunciated in the 4-year Development Plan 1971-75, and reiterated in the Second Plan 1975-80 for Social and Economic Development, was designed to encourage the people of Mauritius to reduce their gross reproduction rate from 1.92 in 1969 to 1.20 by the mid-1980s.

In 1969 two missions from the World Bank visited Mauritius to advise the government on setting up a national family planning program. In December 1970 an agreement was signed between the United Nations Fund for Population Activities (UNFPA) and the Government of Mauritius to implement a five-year family planning, ma-

9

ternal and child health program. Following this agreement in December 1972, the government integrated 62 out of 64 clinics and 29 supply centers of the MFPA within the Maternal and Child Health Services (FP/MCH Services) of the Ministry of Health and set up a National Family Planning Committee to coordinate population activities. The MFPA continued to operate two clinics and to evolve new strategies to reach the population still untouched by existing programs. AF continued functioning as in the past. Upon integration of the MFPA clinics into the government's health infrastructure, the government took a very significant step forward by making contraceptives available to all, free of charge, through program outlets. The MFPA followed suit.

What Caused the Fertility Decline?

With the development of extensive family planning services on the island, particularly during the second half of the 1960s, fertility began to decline, and that decline has continued. To what extent were family planning services instrumental in bringing about that decline?

There are no controlled family planning studies that prove irrefutably that an organized family planning program can produce a fall in fertility. However, if fertility did not decline significantly before the program began, and if family planning program inputs parallel fertility declines, it is hard not to believe that the program accelerated the fall in fertility. Mauritius has sufficiently detailed statistics to demonstrate such a relationship.

The table on page 11 provides some of the key statistics to document the case. As the government services providing family planning were enlarged, the number of new acceptors grew, multiplying more than fourfold from about 3,000 in 1965 to more than 13,000 in 1975. The number doubled from 8,000 to 15,000 in a single year, 1973, when contraceptives were for the first time distributed free of charge. Over the same ten-year period, the mean age of first acceptors dropped from 30.5 to 26.5, increasing the demographic impact of the program. Moreover, by 1975, nearly 60 percent of new acceptors (58.7) had fewer than three living children. Program records, although not adequate to calculate continuation rates, showed about 40,000 current users in 1975.

What have been the effects of this program on fertility? As the table shows, the general fertility rate has declined in a decade from about 180 to about 100. Declines have been greatest in age groups under 20 and over 25 where age-specific fertility rates in 1975 are approximately half as high as they were in 1962. There has been much less decline in the 20-24 age group. (See graph.)

Number of Fertile Women Grows

In 1974, however, the birthrate increased suddenly from 22.7 to 27.1 and gave rise to concern about the program. Closer analysis showed two possible causes: (1) an increase in the number of women reaching marriageable age and peak fertility; (2) an increase in the number of marriages following a substantial gain in the gross national product. Both of these factors were reflected in an increase in the number and percentage of first, second and third births, while fourth and higher orders of birth continued to decline.

In a young population like that of Mauritius, the age structure now tends to encourage higher birthrates. It is inevitable that newly married couples will tend to have their children soon after marriage. In the 1973-74 analysis, out of the 78 percent increase in fertility, 42 percent was accounted for by the first birth order alone. Thus the rise in fertility in 1974 should be viewed in the context of the momentum built up as a result of the very young age structure typical of Third World countries.

At this juncture it could well be asked whether the present age structure will not be a stumbling block to further declines in fertility to levels comparable with the technologically advanced countries. In fact, the crude birthrate registered a slight drop in 1975 to 25.1 per thousand as compared to 27.1 in 1974. In 1976 it is estimated to be around 25.6 per thousand—a marginal increase over the 1975 rate. However, the trend in the number of new acceptors joining the program might be viewed as an indication that the Mauritius Family Planning Program has reached a plateau.

Because of this age structure and because an ever greater percentage of births are first, second or third order, it is not implausible to assume that the crude birthrate in Mauritius is likely to fluctuate around the 1975-76 rate for a few years. The National Family Planning Program is consequently focusing its efforts on younger couples without losing sight of older couples still in their reproductive years.

Meanwhile, as government and private programs have contributed to the important decline in fertility, other government development policies have also achieved significant successes. Life expectancy, for example, has

doubled from the low 30s in 1945 to the mid 60s by 1975. Over the same period, infant mortality has been cut to nearly one quarter the 1972 level. Since 1972, per capita gross national product has doubled. More than 90 percent of the population aged 5 to 11 is enrolled in schools with 46 percent of the males and 34 percent of the females advancing to secondary schools.

These programs may also encourage lower fertility, but at the same time lower fertility will facilitate the achievement of other development goals. For these reasons, Mauritius has adopted a formal and positive population policy designed to reduce the gap between high fertility and low mortality. This effort has been genuinely and largely indigenous through strong local participation and leadership. Nevertheless, foreign assistance, both technical and material, has eased the heavy financial burden and helped the Government of Mauritius fulfill its policy objectives.

Mauritian Vital Statistics and Family Planning Data for Selected Years, 1962-1975

	1962	1965	1970	1972	1973	1974	1975
Number of New Acceptors		3,023	9,900	8,031	15,372[a]	13.601	13,528
Mean Age at First Acceptance		30.5	27.0		26.8	26.8	26.5
Number of Current Users		1,175	24,408	28,062	35,232	38,272	40,408
Number of Family Planning Service Units & Personnel							
Clinics				62	72	76	80
Supply centers				29 (+1)[b]	30	49	43 (+1)[b]
Doctors				3 (+13)[c]	4 (+10)[c]	7 (+10)[c]	15
Clinical assistants				16	16	26	26
Field-workers				63	75	75	84
Motivators				74	73	83	75
Vital Statistics							
Crude birthrate	38.5			24.8	22.7	27.1	25.1
Crude death rate	9.3	8.1	6.8	7.9	7.8	7.3	8.1
General fertility rate	181.4			104.5	95.6	108.9	101.9
Population growth rate %	2.9			1.7	1.5	2.0	1.7
Net reproduction rate	2.5			1.5	1.3	1.5	1.4
Infant mortality rate	60.1			63.8	62.5	45.3	48.7
Percentage of Births by Birth Order							
1			22.9	26.4	29.0	30.6	31.4
2			18.7	19.9	20.6	20.7	22.1
3			14.1	15.2	14.4	14.5	14.0
4			10.7	10.4	10.1	10.1	9.5
5			8.5	7.8	7.3	6.9	6.4
6+			21.1	18.0	16.1	15.4	13.2
Per Capita GNP (at factor cost in rupees)				1,550	1,996	3,489	3,409

[a] Increase in 1973 is attributable primarily to the free distribution of contraceptives.
[b] Mobile van.
[c] Part-time.

Family Planning Progress in Maharashtra

J. R. Rele
Professor and Director
International Institute for Population Studies
Bombay

Tara Kanitkar
Reader
International Institute for Population Studies
Bombay

MAHARASHTRA, with an estimated 1977 population of about 57 million, is the third most populous state in India. Maharashtra includes 9.2 percent of the total population of India and 9.5 percent of its land area. Population density in Maharashtra in 1971 was 164 persons per square kilometer, which is slightly lower than the whole of India. Maharashtra has a higher percentage of urban population than any other Indian state with a little less than one third of its population living in urban areas.

The birthrate in Maharashtra during 1951-60 was 41.0 per thousand population as compared with 41.7 per thousand population in India as a whole. The birthrate remained virtually unchanged until 1966 when it was estimated at 39.8 per thousand for Maharashtra and 41.1 per thousand for the whole country. Since then the gap has widened. By 1974 the birthrate in Maharashtra had fallen to 29.0 per thousand, compared with 34.5 in all of India.

The faster decline of the birthrate in Maharashtra has been consistent with the state's family planning program performance. According to official statistics, family planning performance in Maharashtra stands second only to the state of Haryana. The latter is much smaller in area as well as population. In Maharashtra 35.5 percent of couples were using family planning or were effectively protected in December 1976, as compared with 22.9 percent in India as a whole.

Maharashtra has been the pioneering state in India in the field of family planning. Voluntary family planning was introduced in Maharashtra as early as 1925 when the late Professor R. D. Karve started a birth control clinic in Bombay. For many years his efforts were derided, but he continued to carry the torch for family planning along with other social reforms, and eventually his contribution was recognized. Karve was followed by Dr. A. P. Pillai, who in 1936 conducted a training course on family planning in Bombay. Today Maharashtra retains its leadership and is a front runner in family planning performance among all states in India.

The family planning program in Maharashtra has been steadily gathering momentum for the last two decades as can be seen in the table below. For example, with a mere 41,189 sterilizations during 1957-61, acceptance has grown steadily to 219,241 in 1961-66, 1,150,636 in 1966-71 and 2,037,088 in 1971-76. These are figures through March 31, 1976, the end of the Indian fiscal year and before the intensive campaign began. Although IUD usage has declined, acceptance of conventional contraceptives, especially condoms, has increased greatly.

Progress of Family Planning in Maharashtra 1957-1976

	Sterilizations	IUD	Conventional Contraceptive Users
1957-61	41,189		
1961-66	219,241	130,210	
1966-71	1,150,636	197,945	716,400
1971-76	2,037,088	60,402	1,281,510

Sources: Health Services, Maharashtra State, *Facts and Figures*, April 1975, p. 10.
Department of Family Planning, Ministry of Health and Family Planning, *Monthly Bulletin on Family Planning and MCH Statistics*, May 1976, p. 15.

As in the rest of the country, the family planning program in Maharashtra has evolved through various phases. The first approach was clinic-oriented, but it failed to reach the people and resulted in poor performance. In 1963 the extension outreach approach was adopted. This boosted performance fivefold in a short time span. Nevertheless, recognizing that family planning had not yet reached the masses, the government of Maharashtra in

1967 reviewed the situation and after deliberation among the cabinet ministers made certain momentous decisions regarding the state family planning program. **The outstanding features of the new policy were an emphasis on sterilization and a complete involvement of the Zilla Parishads (district councils) in the program. The results were remarkable. During the Fourth Five Year Pian, the performance in Maharashtra reached a new high level of 1.15 million sterilizations. During the next five years (1971-76), the figures rose still further with more than 1 million sterilizations recorded.**

Decentralization Crucial

Crucial in this context was the democratic decentralization of powers introduced in Maharashtra in 1962. The Zilla Parishad is a democratic organization of locally elected representatives, which has jurisdiction over a district. With the exception of Greater Bombay, which is entirely an urban district, each of the remaining 25 districts of Maharashtra has one Zilla Parishad. The Zilla Parishad is responsible for the development activities of the districts and the participation and involvement of the people in the development process through their elected council members. The district health officer in the area covered by the Zillia Parishad is in charge of the family planning program in the district.

Each district is divided into various community development blocks. The development activities at the block level are looked after by a body of elected members known as Panchayat Samiti. The medical officers at the block level manage the family planning program of the block. Thus it can be seen that when the Zilla Parishads were entrusted with implementation of the family planning program, the program in the district in a sense became a "people's program." This policy of involving the people through their elected representatives undoubtedly has an influence in boosting program performance.

In 1971 the International Institute for Population Studies in Bombay conducted a study on the involvement of Zilla Parishads in the implementation of the family planning program. In this study six districts of Maharashtra were compared, including two with very good performance in family planning, two with medium performance and two with very poor performance. **It was observed that the involvement, active support and participation of the district leaders in the family planning program had great impact in improving family planning**

performance both at the district and block level. Districts where leadership involvement was greater had superior family planning performance compared with those where this involvement was lacking. In effect, active support by the local official and unofficial leaders appeared crucial in promoting family planning, especially for methods like

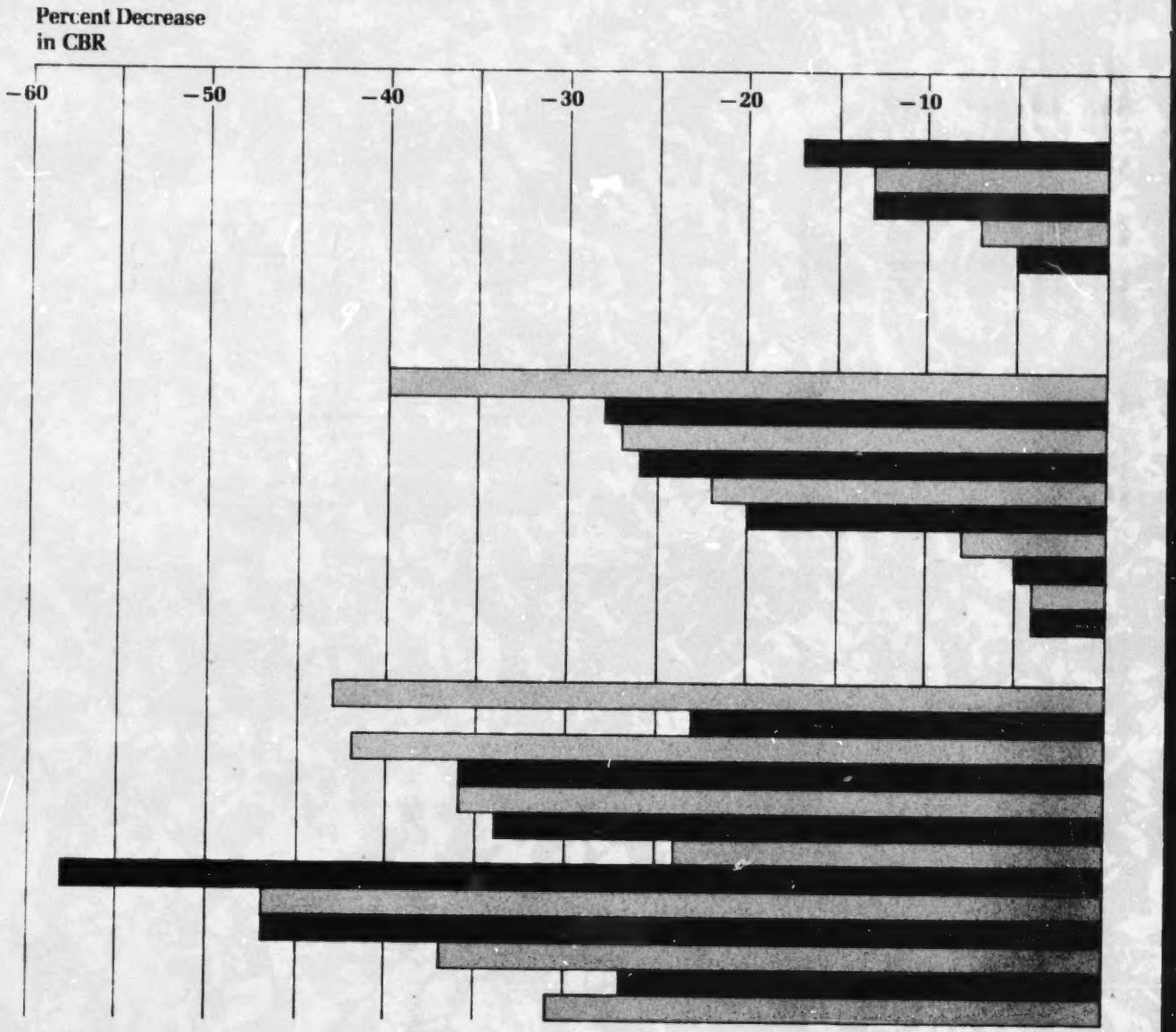
sterilization and the IUD. The support of these leaders helped in building the confidence of the people in the program as well as in the specific methods and also helped in supporting the follow-up action so essential in a mass program like family planning. In the districts or blocks where family planning achievements were consistently better, it was observed that the local leaders helped the doctors in several different ways such as enlisting acceptors; arranging for follow-up, after-care and encouragement; informing doctors of cases needing medical help; and in general ensuring more medical attention when needed.

Moreover, the interest, support and involvement of local leaders was found to facilitate the work of the officials who were in charge of the program. Some of the leaders accompanied the doctors and provided necessary help. **Sometimes the leaders or their wives accepted vasectomy or tubectomy and acknowledged it publicly in order to win the confidence of the people in these methods. Thus they set an example for others to follow and practiced what they preached.**

Another important feature of the Maharashtra Family Planning Program was the involvement of other departments at the district level. This was understandable because the family planning program in Maharashtra was viewed as one of many development programs. For instance, in one district where 72 percent of the area is covered by forest, the support of forest officers proved to be a great help to the program. Some incentive schemes were also initiated by the government to promote the program at the village as well as the individual level. Villages with better family planning performance were rewarded through development schemes such as building roads or public wells.

Through various imaginative schemes, Maharashtra State has been in the forefront of the voluntary family planning program in India. What seems to have been most crucial in the success of the program is the involvement of the people themselves through their official and unofficial leaders at the community level.

REDUCTIONS IN THE CRUDE BIRTH RATE IN SELECTED DEVELOPING COUNTRIES, 1955-1974



These data were cited in an address by Robert S. McNamara, President, World Bank, to the Massachusetts Institute of Technology, April 28, 1977. They were prepared from the Population Council, *Population and Family Planning Programs: A Factbook, 1976*, with subsequent modifications by Parker Mauldin, Population Council and recalculations as needed. Most of the percentages can be considered accurate only to within about ten percentage points and may not agree exactly because of rounding.

Country	CBR in 1955	CBR in 1974	1975 Population (in millions)
Group I (over 50 million)			
India	43	36	598
Indonesia	46	40	132
Mexico	46	40	60
Brazil	41	38	108
Pakistan	49	47	70
Bangladesh	49	49	79
Nigeria	49	49	63
Group II (20 to 50 million)			
South Korea	40	24	35
Colombia	46	33	25
Thailand	47	34	42
Turkey	45	33	39
Egypt	44	35	37
Philippines	45	36	42
Burma	43	40	31
Ethiopia	51	48	28
Iran	47	45	34
Zaire	47	45	25
Group III (under 20 million)			
Africa – Mauritius	44	25	0.9
Tunisia	47	36	5.6
Americas – Costa Rica	48	28	2.0
Chile	36	23	10.3
Trinidad & Tobago	41	31	1.7
Barbados	32	21	0.2
Panama	41	31	1.7
Asia – Singapore	43	18	2.3
Taiwan	44	23	16.0
Hong Kong	35	18	4.4
Fiji	44	28	0.6
Sri Lanka	38	27	13.6
Malaysia	45	31	10.5

Chinese Birth Planning: What Makes It Work?

Dr. Pi-chao Chen
Associate Professor of
Political Science
Wayne State University
Detroit, Michigan

IN the early 1960s after initial vacillation, the Chinese political elite took vigorous, even prodding, action to spread birth planning and lower fertility. Why was this done? Believing rampant population growth to be incompatible with a planned socialist economy, the elite recognized that current rates of population growth could not be rapidly reduced or stabilized merely through government appeals to practice responsible parenthood.

The problem ultimately required a fundamental extension of social morality by limiting the freedom to get married at an early age or have as many children as desired. Such actions were not arbitrarily imposed by administrative fiat but, rather, through mobilizing social and community pressures. **Rather than codify reproductive norms into law, the Chinese government recommended three basic social changes: delayed marriage, spaced births and abandonment of the traditional preference for sons.**

In the last decade, the Chinese government has greatly expanded and strengthened the nationwide network of integrated rural health care and planned birth services by bringing on-the-spot preventive health care, simple curative treatment and contraceptive supplies to the rural villages. At the same time, the government has encouraged and prodded local communities to work out their own community population planning mechanisms to reduce and stabilize fertility.

High Priority for Birth Planning

Since the mid-1960s, the Chinese elite have designated the rapid universalization of basic level health care and the extension of planned birth work as tasks of the highest priority. **This priority status has meant that the administration at all levels must draft plans with targets and time schedules and must mobilize all available resources to reduce fertility.** Virtually all political, quasi-political (*e.g.*, the Young Communist Leagues, the Women's Federations) and health units have been pressed into service and have been assigned tasks. Practical methods for implementing birth planning policies have been devised at the grass-roots level, and performance is continually monitored and periodically evaluated by the central government, which holds the party and health bureaucracies strictly accountable for accomplishment of tasks.

Where population programs in other developing nations have focused on promoting and facilitating birth limitation among married couples of reproductive age, in China the program emphasizes late marriage and the spacing of births in addition to small family norms. Some other countries have set a minimum legal marriage age somewhat higher than the traditional marriage age, and some programs have preached the need for birth spacing without setting specific guidelines for family size. No other country, however, has specifically sought to exploit late marriage and birth spacing as instruments of reducing fertility. By asking young people to abstain from bearing children between the ages of 18 and 25, the Chinese government's encouragement of a widespread practice of late marriage has sought to lower the intrinsic birthrate and, hence, the intrinsic growth rate on the assumption that if women marry at age 25 rather than age 18, four rather

Summarized from the findings of Dr. Chen's monograph, *Population and Health Policy in the People's Republic of China*, Smithsonian Institution Interdisciplinary Communication Program, Washington, D.C., 1976. Distributed by NEO Press, P.O. Box 32, Peaks Island, Maine 04108.

than five generations will be born within a century. In a society where marriage has traditionally occurred in the middle to late teens, the change to a later marriage age is even more dramatic.

Although the goal of most family planning programs to have couples limit families to two or three children would appear to be an equally good approach to reducing fertility, in reality it is an unrealistic goal if couples marry young. After having two to three children, these couples probably will not undergo sterilization despite the more than 20 years of reproductive life that lie ahead for the wife.

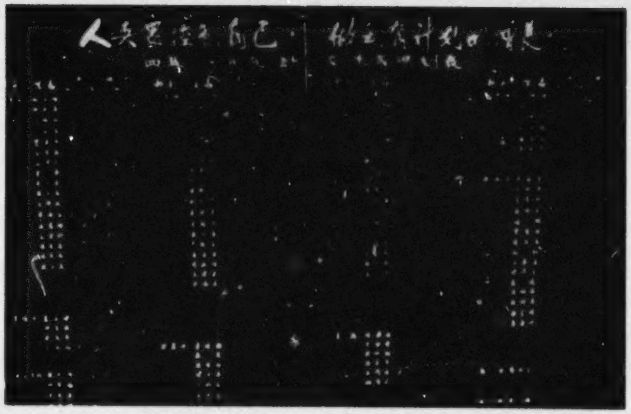
Community Planning of Births

In the last several years, an increasing number of communities in China have adopted a model that may be called community planning of births. The following example illustrates how community planning of births is accomplished in a commune, the lowest administrative unit in the rural areas.

On the basis of vital statistics from the previous year, the commune leadership may suggest that the crude birthrate be reduced from 25 per 1,000, the rate of the previous year, to 22 per 1,000 for the next plan year. This suggestion is passed down until it reaches the lowest level, the production team. The eligible couples in the team meet to draw up the team birth plan. They calculate the number of births that would yield the suggested birthrate and then proceed to "allocate birth turns" among themselves. Priority is given first to newly married couples and childless couples, second to couples with only one child and third to couples with two children or couples whose youngest child is closest to age four or five. These priorities are based on the new reproductive norms promoted by the government:

- Young people should not get married until they reach the recommended (or optimal) age of marriage (25 for men and 23 for women; 28 and 25 respectively in cities).
- Each couple is to space births at four to five-year intervals.
- Each couple should limit family size to three children (two in cities), regardless of sex.

Couples thus allocated the "birth turn" abstain from practicing contraception while the others continue to practice contraception. Obviously adjustments have to be made for failure to conceive during the plan year, for



This master chart, posted on the wall of a clinic of a silk textile plant, Soochow, Kiangsu, People's Republic of China, lists the names of married women workers by the years in which they plan to bear children during the Fourth and Fifth 5-Year Plans (1971-1975 and 1976-1980).

unplanned pregnancies due to contraceptive failure and for unanticipated developments. Such adjustments are made by mutual agreement at group meetings. In this way, the community as a whole reduces its fertility year after year until a very low fertility rate is achieved. Once the low fertility rate is realized, the task becomes one of stabilizing fertility at the low level.

Spectacular Decline in Kiangsu

Community planning of births has not been spread to all parts of China but in the last several years, the Chinese government has made vigorous efforts to disperse community-level population planning throughout the country. **Where community planning of births has been implemented, the results have been spectacular. According to the official newspaper,** *People's Daily* **(Jen-min Jeh-pao) of February 22, 1977, "The natural increase rate of population for the province of Hopeh and Kiangsu [with a population of more than 50 million in 1974] has declined from 20 per 1,000 in 1965 to around 10 per 1,000 as of now. The municipalities of Shanghai and Peking have controlled the rate under 6 per 1,000." There is no way of determining the validity of the claim. If true, however, the population programs in the two provinces and two metropolises must be regarded as the greatest success story of organized population programs in history.**

Barefoot Doctors

In other developing nations, the official population program usually is the responsibility of a ministry of family planning (*e.g.*, Pakistan) or of a specially created bureaucracy (*e.g.*, Indonesia, the Philippines, Malaysia) or of a component unit of the ministry of health (*e.g.*, India). To the extent family planning programs are integrated with other development projects, the integration goes only as far as merging the family planning services with maternal and child health services.

In China there are no separate planned birth organizations below the county level. The rural health service has been integrated within the existing social and economic fabric at the grass-roots level. Following a decision in 1968 to universalize cooperative health services, Peking called upon the local party and revolutionary committees to organize recruitment and training of barefoot doctors and to establish cooperative health stations. Upon completion of their training, the new barefoot doctors returned to their own brigades to practice their newly acquired skills at the brigade cooperative health station erected for them.

The policy goal has been to train and deploy one barefoot doctor for every 500 rural population. There were 1.5 million barefoot doctors by the end of 1976. If China had a total rural population of 750 million in 1976, the policy goal may be regarded as having been realized by the end of 1976. Henceforth, the task will be to upgrade the quality and skills of the barefoot doctors through continued in-service training.

Having helped train the barefoot doctors, the state assists them in the following manner: (1) by providing all preventive health and birth control supplies free of charge; and (2) by reducing the price of, or subsidizing, pharmaceutical drugs and equipment sold to rural communities. Depending upon need, the state may also provide a nonrecurrent grant to low-income brigades to help them get their cooperative health stations established and operating.

Local Self-reliance

The local community is expected to manage the station and finance its operation largely through local resources by setting up a cooperative medical fund derived from premiums paid by individual members and through appropriation from the brigade's (and sometimes the commune's) welfare fund. All management decisions are made and enforced locally. Needless to say, the fact that the paramedical service is financed largely by local resources and under local community management tends to make the local people regard it as their own—a condition vital to the long-term viability of the service.

Barefoot doctors are selected by the local community because of their class background, ability to work with people and dedication to serving the people. Instead of waiting for people to come to the clinics, the barefoot doctors, sanitarians and women's work cadres* often personally deliver supplies. All of these qualities, plus the fact that these people are paid by and are under the control of the local community, tend to make the barefoot doctors responsive to the needs and feelings of the community.

The dual financing system enables the government to achieve a high degree of outreach with a limited budget and also enables the government to concentrate its scarce resources on subsidizing preventive health and planned birth services.

Three Strategies

The following strategies used by the Chinese in their birth planning program are of great significance:

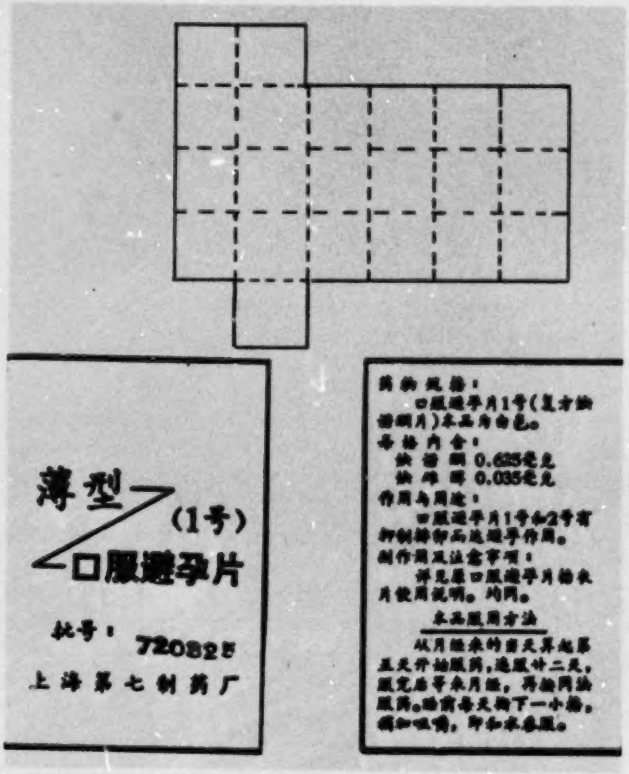
(1) **The principle of leadership by personal example.**

*In current Chinese usage, the word *cadre* applies to any nuclear group in a responsible position in any organization of government, party, industry, agriculture, military or cultural life. A key word in Chinese Communist terminology, *cadre* also implies ideal leadership and loyalty.

No matter what a cadre's position or work, each cadre must practice late marriage, birth spacing and birth control to demonstrate the benefits of smaller families and the safety of contraception or sterilization.

(2) **The psychological mechanism of group dynamics.** Group meetings have been used to unfreeze many traditional norms; since the early 1970s the same procedure has been increasingly used to change norms on marriage age and reproduction. By 1973 the extension of group planning births in urban centers resulted in remarkably low birthrates in the cities for which data are available.

A large billboard sign exhorts a cyclist to DO A GOOD JOB ON PLANNED BIRTH FOR THE SAKE OF THE REVOLUTION.



The perforated sheet of paper is actually a series of female oral contraceptives which dissolve on the tongue. Also shown are the front and back of the card carrying instructions for their use. Dosage corresponds to that of the well-known "pill"—one pill or square a day for 21 days, with a week's interval before starting the cycle again. The paper contraceptive was developed in China.

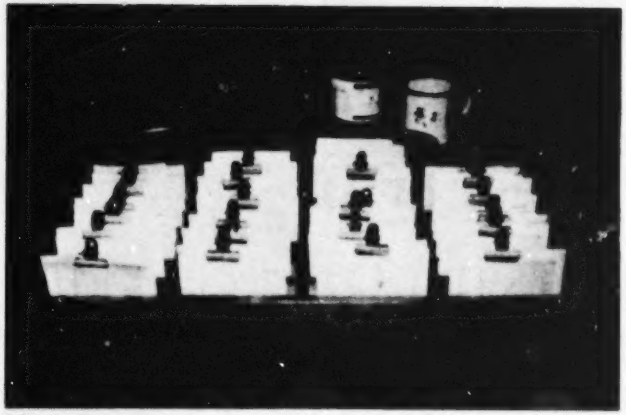
(3) **Collectivized agriculture.** The work-point system, which is used to remunerate members of the rural production team or brigade, has accomplished two objectives: increased productivity and demographic restraint. Combined with the agricultural taxation policy under which an individual production team is assessed a fixed amount, rather than a fixed rate, the work-point system provides a strong incentive for increased output so that the amount divided among the members is maximal. At the same time, it also encourages the production team to keep its members from increasing so that the maximum earnings are divided among the fewest possible persons. **In a context where the rural villages have been denied the option of**

rural-to-urban migration as a way of siphoning off surplus manpower, this economic consideration tends to impel the rural community leadership to internalize the cost of excessive, or unplanned, population growth.

The main deficiency of the Chinese program is the lack of standardized evaluation procedures. Most Asian programs have centralized research and evaluation units at their headquarters for the purpose of engaging in demographic analysis, anticipating bottlenecks and suggesting or testing ways of improving performance. These structures, however, are often created with technical help and financial assistance from abroad.

A Rational and Realistic Choice

In conclusion, China's population program differs significantly from programs in other countries in the employment of organizational arrangements, social and cultural changes and development strategies. Not only is the planned birth program integrated with the health care system, it is also built into the political, administrative, social and economic infrastructure at the grass-roots level. The Chinese program is distinguished by the degree of leadership commitment, as measured by the comprehensive action taken and the resources and manpower invested, as well as the extraordinary organizational capacity developed in pursuit of policy goals.



File of planned birth cards at "East is Red" silk textile plant, Soochow, Kiangsu.

Furthermore, the Chinese elite's commitment to egalitarianism and distributive justice has the effect, intended or otherwise, of facilitating their efforts to make small families a rational and realistic choice for the vast majority of the population.

Population Estimates for the People's Republic of China

Source	Population size (billions)	Birthrate (per 1,000 population)	Death rate (per 1,000 population)	Rate of natural increase (percent)
John S. Aird, US Dept. of Commerce (1972)	930	37	13	2.4
United Nations (1973)	839*	27	10	1.7
Leo A. Orleans, US Library of Congress (1975)	850	27	12	1.5
Worldwatch Institute (1975)	823	19	8	1.1
R.T. Ravenholt, USAID (1975)	876	14	6	.8

Sources: Tomas Frejka, "One-fifth of Humanity," *People*, Vol. 3, No. 3, 1976; Worldwatch Institute, World Population Trends, No. 8, October 1976.
*Includes Taiwan, 14 million.

The lowest birthrate recorded in South Asia

Family Planning Helps in Sri Lanka

Dr. (Miss)
Siva Chinnatamby
Honorary Medical Director
Family Planning Association of
Sri Lanka

IN the first 50 years of this century, the crude birthrate in Sri Lanka remained fairly steady at about 38 per thousand population, but since 1960 the birthrate has steadily declined to a low of 27.2 in 1975—the lowest birthrate recorded in South Asia. **This rapid decline can be attributed to two factors: first, a decline in the percentage of married women in the critical high fertility age group under 30, and second, a decline in fertility among married women, especially those under 30.**

Both factors may carry important implications for developing countries. The reasons for nonmarriage or delayed marriage are both demographic and economic. A young woman in Sri Lanka usually marries a man about five years her senior. Because the annual number of live births rose steadily between 1940 and 1962, there are many more women at the age of 25, for example, than there are men at age 30. The growing rate of unemployment and economic uncertainty for young men has also discouraged many young people from marrying. As a result, according to the 1971 census, only 10.3 percent of women age 15-19 were married, compared to 23.7 percent in 1953; only 45.9 percent of women age 20-24 were married, compared to 65.6 percent in 1953; and only 73.5 percent of women aged 25-29 were married, compared to 84.4 percent in 1953. Altogether, at least 20 percent of the women now reaching the age of 30 are not yet married, and many of them may remain unmarried. High literacy rates and continued education for women and men also discourage early marriage.

Declines in fertility among those already married are obviously the result of successful family planning efforts. Among eligible couples, about 43.8 percent are now using

contraceptive methods, including pills, IUDs, long-acting injectables and conventional methods like the condom. Family planning services are readily available from public health midwives in the field, from facilities operating in all government hospitals, including many with post-partum tubal ligation services, and from commercial sources. An extensive health infrastructure combined with high rates of female literacy (80 percent) makes it easier for women to find and use these family planning services. Male vasectomy services have also become popular.

Densely Populated Island

In 1971 the overall density of Sri Lanka was 529 people per square mile, making it one of the most densely populated agricultural countries in the world. About 60 percent of the population is concentrated in the Wet Zone, which comprises only 23 percent of the Island's area. Population characteristics, such as average age at marriage and marital fertility, differ widely between the Wet and Dry Zones. The population in the Dry Zone has a lower average age at marriage (21.5 years compared to 24.5 years in the Wet Zone), higher fertility and a higher-than-national-average growth rate.

The population of Sri Lanka, now more than 13 million, has grown five and one-half times since the first national census of 1871, which recorded only 2.4 million people. The first population doubling took place in the 58 years between 1871 and 1929; the population doubled again in the 30 years between 1929 and 1959. In 1960 the annual growth rate reached an all-time high of 2.8 percent.

Over the past 30 years, Sri Lanka's population has undergone a classical demographic transition in three stages:

1. Until 1946, high birthrates and high death rates prevailed.
2. From 1947 to 1966, high birthrates continued while death rates declined markedly, mainly because of control of epidemic diseases like malaria, a rapid fall in infant mortality and improved maternal health services throughout the country.
3. From 1967 to date, birthrates have declined and the death rate has remained relatively low.

The decline both in the number and the fertility of married women was recently documented by George

Immerwahr, formerly with the World Health Organization in Sri Lanka. As the following table shows, if all women had experienced the same age-specific fertility rates in 1975 as in 1963, there would have been a total of 529,000 births. If age-specific fertility among married women had remained the same, births would have totaled 445,000. Actually, only 375,000 births were recorded (provisional) in 1975. Thus, a total of 154,000 births were averted in 1975, of which 84,000 may be attributed to a lower percentage of women married and 70,000 to lower fertility within marriage.

Cooperation in Family Planning

Increased contraceptive use, facilitated by easily available services and a widespread awareness of modern family planning methods, has been an important factor in Sri Lanka's rapid transition to lower fertility.

The family planning movement in Sri Lanka began following a visit to the island in 1952 by Margaret Sanger and Abraham Stone. The Family Planning Association

and Abraham Stone. The Family Planning Association (FPA) was founded in 1953 and became a member of the International Planned Parenthood Federation in 1954. At that time it established clinics and offered services mainly in Colombo and its suburbs.

In 1958 the government entered the family planning movement by accepting a Swedish government offer to establish pilot projects in community family planning programs. Swedish assistance, a major international input in the country's population program, has been in the form of contraceptive supplies, technical assistance, clinic equipment and transportation. In 1965 the government incorporated family planning into the maternal and child health care services of the Ministry of Health.

In 1973, following a review by a United Nations interagency mission, the government of Sri Lanka and the UN Fund for Population Activities signed a Joint Multidisciplinary Project Support Agreement. Under this agreement, UNFPA is providing assistance totaling $6 million over a period of four years.

Also in 1973, Population Services International (PSI) introduced an experimental community-based distribution program for distribution of condoms in rural areas. In 1975 the project was transferred to IPPF and expanded to include the marketing of oral contraceptives.

Reaching the Grass Roots

Today the FPA carries on a wide range of projects designed especially to reach the grass roots. In cooperation with the Ministry of Labor, the FPA has established a male sterilization clinic which operates in conjunction with motivational activities in the estate sector. The clinic has been a great success. Training of medical and paramedical personnel for family planning is also an important FPA task. Voluntary sterilization, both male and female, has proved to be very acceptable in Sri Lanka, especially with modern advances in surgical techniques and the consequent reduction in the length of hospitalization required for female sterilization.

Sri Lanka thus provides a good example of an active private organization and an extensive government program working in cooperation to encourage lower fertility. Social and economic conditions, as well as a demographic pattern that has helped reduce early marriage, have also contributed to hastening the demographic transition in Sri Lanka toward a more modern balance between low birthrates and low death rates.

Sri Lanka Vital Statistics, 1946-1975

	1946	1953	1963	1971	1975*
Crude birthrate	37.4	38.7	34.4	30.1	27.2
Crude death rate	20.2	10.9	8.5	7.7	8.5
Natural increase (%)	1.7	2.8	2.6	2.2	1.9
Infant mortality (per 1,000 live births)	141	78	56	43	n/a
Maternal deaths (per 1,000 live births)	15.5	4.9	2.4	1.5	n/a
Life expectancy at birth:					
Male	43.8	57.8	62.8	64.0	n/a
Female	41.5	55.7	63.0	66.9	n/a

Source: Sri Lanka Department of Census & Statistics.
*1975 figures are preliminary.

Closing the fertility gap between rich and poor by making services fully available

Impact of US Family Planning Programs

Frederick S. Jaffe
President
Alan Guttmacher Institute

AFTER decades of insistence that birth control was not the business of the US government, in 1965 federal involvement in family planning began with an $8,000 antipoverty grant to a Planned Parenthood program in Corpus Christi, Texas. That small and tentative investment has since grown to more than $200 million annually. The bases of the federal program are organized clinic services, which with federal support now provide modern methods of contraception to nearly four million patients. Almost all are low-income women; the remainder are individuals who have experienced difficulties in obtaining contraception for such reasons as age, marital status or rural residence. **In fact, during the first half of the 1970s, the US family planning program helped these women to avoid more than one million unintended births. Altogether over the last decade, the program has helped reduce the traditional gap in fertility between rich and poor by about one fourth.**

Development of the US family planning program was accelerated by Congressional enactments in 1967 and 1970, by the reports of a Presidential committee in 1968 and by the US Commission on Population Growth and the American Future in 1972. The rationale for the program was based on the findings of nationwide fertility studies in 1955 and 1960, indicating that US couples of all socioeconomic and ethnic groups desired small to moderate-sized families, approved of fertility regulation, and had tried to limit their family size with one or another contraceptive method. At the same time, however, the studies revealed a significant proportion of unwanted and mistimed births, particularly among low-income and poorly educated couples who relied disproportionately on the least effective, nonmedical methods of contraception. Accordingly, the family planning program gave priority to increasing the access of low-income individuals to contraceptive services.

Program Assumptions

Although some have argued that the basic problem is motivation, that the poor want more children and are not willing to plan reductions in fertility, US programs have been based on the primary need to assure low-income families and individuals full availability of and access to family planning services. This emphasis is based on five specific assumptions:

(1) The major reason low-income people have relied on less effective nonmedical contraceptives is because they have not had access to physicians who control the distribution of the more effective medical methods.

(2) If effective medical contraceptives were to be made available and accessible, and if information about their availability were widely disseminated, low-income people would use them.

(3) Greater use of effective contraceptives would lead to greater success in avoiding unintended pregnancies and would be reflected in lower fertility rates.

(4) A public program could effectively increase availability and accessibility for low-income people by financing expansion of the supply of contraceptive services through existing health institutions or, if necessary, by creating new agencies devoted primarily to delivery of family planning services.

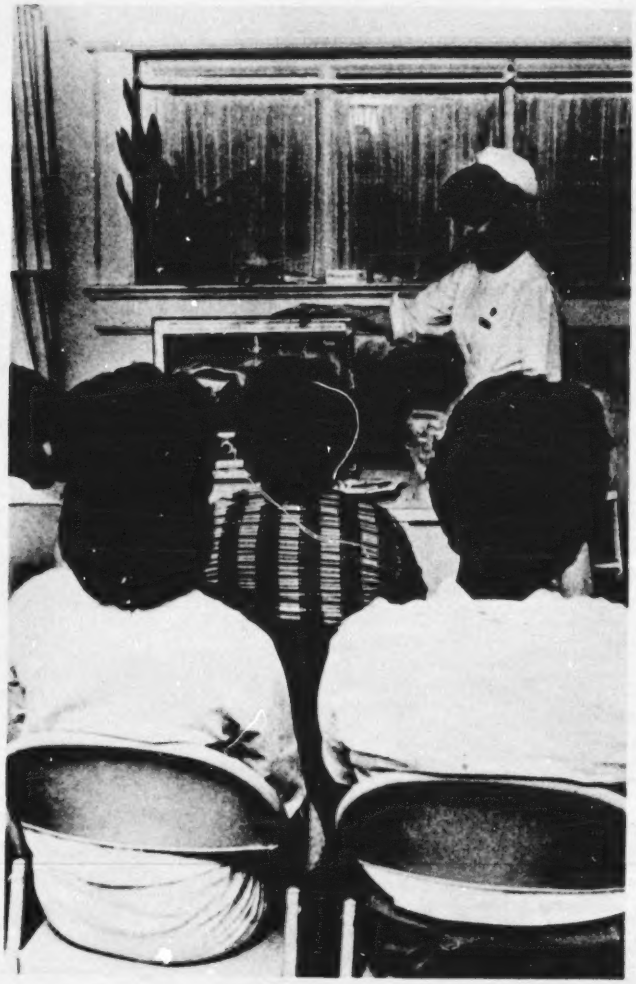
(5) Successful adoption of effective contraception by a significant proportion of low-income people would encourage other low-income people to adopt modern

methods and would be more effective than exhortation in influencing motivation to regulate fertility.

Program Accomplishments

These assumptions have proved well-founded. Certainly over the last decade the accomplishments of the federally funded US program have been notable.

- Between 1966 and 1976 the number of people served by organized family planning clinics increased from 540,000 to 3,924,000—an increase of more than sevenfold.



- In all years for which data on the socioeconomic status of patients are available, clinic users were predominantly of low- or marginal-income. In 1975 nearly 6 to 10 of all patients were below the official federal poverty index, 8 in 10 were below 1½ times the index, and 9 in 10 were below 2 times the index.
- An increasing number and proportion of clinic patients are young women who seek effective contraceptive services before the beginning of childbearing. Although in 1969 only one fifth were under 20 years of age, by 1975 the median patient age was 23; nearly one third were 19 years of age or younger, and nearly half had never borne a child.
- The primary function of the clinics is to introduce contraception to many low and marginal-income women who have never used it and to upgrade the contraceptive practices of others. In 1975 nearly half of new patients used no method, or less effective methods, prior to clinic enrollment; after enrollment, more than 8 in 10 used pills, IUDs or sterilization. The change was even more dramatic for teenagers: Before enrollment, two thirds of adolescents used nothing or the less effective methods while after enrollment more than five out of six used the pill and the IUD.
- In 1966 clinic services were provided by fewer than 600 agencies and were concentrated in the nation's largest cities. Today family planning clinic services are provided in about three fourths of the United States by more than 3,100 different organizations—health departments, hospitals, Planned Parenthood affiliates and other agencies.
- In addition to contraceptive services, family planning clinics provide a wide range of preventive health services. In 1975 more than three million patients received Pap smears, breast and pelvic examinations, blood pressure checks, VD tests, urinalyses and blood tests. In fact, family planning clinics have become the nation's largest providers of preventive health services for low-and marginal-income women of childbearing age and for adolescents in all socioeconomic groups. This holds true even though more than 7 out of 10 clinics that offer family planning services are specialized only or primarily in family planning services.
- The number of new and continuing patients served by clinics comprised about one third of the estimated 9.9 million low and marginal-income women at risk of unwanted pregnancy during 1975. It is estimated that an additional 20 percent, some of whom had their services

paid for by Medicaid and other publicly financed programs, received services from private physicians.

Accessible Services—A Key Factor

These operational measures of program achievement are sufficient to confirm most of the hypotheses on which the program was based. In other words, federal programs increased the supply of effective contraceptive services by providing funds to health departments, hospitals and other agencies for the delivery of these services. The services became more accessible and available. This led to substantially increased use by low- and marginal-income people and to marked upgrading of contraceptive practices among this segment of the population. **This could only have happened if the program's first hypothesis were also correct: The principal fertility control problem experienced by low-income people was lack of access to effective methods.**

In the last five years, a number of other studies have provided evidence supporting the conclusion that the program has a significant effect on low-income fertility. In 1972, based on National Fertility Study data, Norman Ryder and Charles Westoff showed that although there was a 36 percent decline in unwanted births among all US couples during the last half of the 1960s, the decline was 47 percent among the least educated and 56 percent among blacks—two subgroups that are disproportionately represented among the low- and marginal-income patients served by the program. Two years later, James Sweet used US Census Bureau data to show that the decline in US fertility during the 1960s was most pronounced among blacks, American Indians and Mexican-Americans. In 1974 the author demonstrated that the fertility decline between the last half of the 1960s and 1971-72 was greater among the low- and marginal-income women from which the program's patients are drawn than among higher-

income women. Last year Robert Weller used data from three National Natality Surveys to demonstrate that the proportion of nonwhite marital births defined as unwanted by the parents declined from 21 percent in 1968 to 10 percent in 1972 while the reduction among whites was from 12 to 8 percent.

To provide a direct test of program effects on low-income fertility, Phillips Cutright and the author carried out a systematic national multivariate analysis with extensive statistical controls using data for each US county on enrollment in family planning clinics in 1969 and the fertility of white and black women in various socioeconomic groups in 1970. **We found a consistent pattern indicating that the higher the proportion of low- and marginal-income women estimated to need family planning who are actually enrolled in clinics, the lower their fertility.** Independent of other social, economic and cultural factors, statistically significant program effects on fertility were shown for almost all subgroups of blacks and whites in the lower socioeconomic groups and teenagers of all economic groups from which the program's patients were drawn. Thus, even at an early stage in the growth of the US national family planning program, it had demonstrable effects on reduction of fertility with the result that low and marginal-income women and adolescents of all income groups were provided with access to modern, effective contraceptive methods that they would not otherwise have had.

Extrapolation of these study results to 1975 suggests that the program succeeded in helping its patients avert more than one million unintended births and that the saving to the government within the following year from these averted births was in excess of $1 billion. The extrapolation also suggests that a hypothetical, fully implemented program serving all who are estimated to be in need of family planning services could go a long way toward reducing remaining fertility differentials among socioeconomic groups in the United States.

Fertility of the Poor Declined Faster

As the table shows, fertility in the United States for all women has declined markedly in the last decade. But the fertility rate of poor women (those with incomes below 125 percent of the poverty index) went down by 48.3 births per 1,000 women of reproductive age, whereas the fertility of higher-income women declined by 35.5 births per 1,000. To put it another way, the fertility of poor women today is approaching that experienced by more affluent women in the early 1960s. Poor women lag about a decade behind higher-income women in using contraceptive services effectively.

US Fertility Declines, 1960-65 to 1973-75

	1960-65	1973-75	Difference
Fertility rate, all US women	109.6	68.9	40.7
Fertility rate, women under 125% of poverty index	152.5	103.8	48.3
Fertility rate, women over 125% of poverty index	98.1	62.6	35.5

A related study by Michael Hout showed how the proportion of low-income women in need who are served by family planning clinics can be increased by deliberate policy actions. Also using multivariate analysis, Hout demonstrated that the most powerful factors determining how many of those in need are actually enrolled in clinics are the number of agencies providing family planning services and the number of clinic locations at which the services are provided. **In other words, the more possible opportunities there are for services, the higher the user population. These variables are very sensitive to policy change as increased funding can relatively quickly induce more agencies to become providers and others to add new clinic locations.**

Family planning programs in the United States and developing countries have been subjected to more continuous and more careful evaluation than any other large-scale social, educational or health intervention. Why this should be so is not immediately self-evident, but its main effect is that family planning programs are called on to sustain a burden of proof significantly greater than other service programs.

Family planning programs have generally sustained that burden of proof. The US evidence, gathered from voluminous operational and research data, shows that US programs have indeed accomplished a substantial part of what they were created to accomplish.

Making Family Planning Work

In a number of developing countries, birth rates have fallen as rapidly during the last decade as they did in Europe and the United States during the whole 19th century. As World Bank President McNamara documented in a recent speech and as the figures on pp. 16-17 show, some developing countries have experienced declines of more than 40 percent in less than 20 years.

What has precipitated these rapid declines in fertility? What has caused a fall in birth rates, even in the United States, that is much greater than previous national and international projections? How have organized family planning programs contributed to reducing the fertility of the 1950s?

In this report, the Draper World Population Fund has reviewed the impact of family planning programs in six areas—from Colombia to China, from the United States to Sri Lanka, from Maharashtra state to Mauritius.

More different than alike, these six areas include small islands and near-continents; rich, poor, and intermediate economies; democratic, totalitarian, and socialist governments; and most of the world's races, religions and cultures. Most have experienced some improvement in living standards, some increase in per capita income, some gains in literacy and opportunities for women. Most have also seen inflation, unemployment and population pressures threaten the quality of individual life even as the aggregate quantitative measures of progress and prosperity have apparently gained.

Impact of Family Planning Programs

In all of these countries, a key factor in declining fertility has been organized family planning programs. At one extreme, in the Peoples' Republic of China a social and political revolution has occurred. As a result, the government's "birth planning" program is backed by pervasive social pressures for late marriage and small families as well as a total redistribution of power and wealth. At the other extreme, in Colombia the government has kept hands off while the private family planning association has built a national program reaching from urban slums to mountain villages and using community-based workers to bring services and supplies to their friends and neighbors. In the United States, a developed country with an already low birth rate, the federal government has funded family planning services for low income families, with a resulting decline in the traditional gap between the fertility of higher and lower income groups. In most countries, governments and private groups have worked together in service and education programs. But in every case, the number of workers and facilities, the amount of public concern and attention, the availability of supplies and personnel to serve the population have been the overriding elements that have determined how many people practice family planning and how rapidly birth rates decline.

Other factors—better health, education, housing, opportunities for women, and local community involvement—can encourage people to have smaller families, but these require long-term government programs and vast sums of money. Family planning programs, on the other hand, have a direct impact. They can be initiated rapidly and require only limited resources.

Impact of Private Voluntary Organizations

In the family planning field, private voluntary organizations can have a direct impact, too, by stimulating and supporting the kind of family planning programs that reach the grass roots and win the support of the people as well as the political leaders.

The private sector has led the way in pioneering such programs and in persuading governments to give higher priority to the family planning needs of their people. These efforts are beginning to bear fruit in the declining birth rates of many countries.

But the problem is far from solved. The number of young adults in the developing world in their prime reproductive years will increase at least 20 percent by 1990. These potential parents are already born—more than one billion children now under 15. Unless they can be reached and helped to have smaller families than their parents did, birth rates will remain dangerously high. Governments have been reluctant to move into the fields of paramedical activity, sex education, effective mass media information and peer group efforts to reach the younger generation, the poorest of the poor, and the millions of remote villagers who rarely visit town and city clinics.

This is where the private sector must continue to lead the way, building on past successes, proving that family planning works when it really reaches the people, and generating the public support that is needed to bring family planning directly into every village and home.

Population Crisis Committee

Officers
Acting National Chairman
Fred O. Pinkham

Honorary Chairmen
William H. Draper, Jr.
1894-1974
William S. Gaud
J. George Harrar
James W. Riddleberger

National Co-Chairmen
Mrs. Angier Biddle Duke
Joseph D. Tydings
Robert B. Wallace

President
Lawrence R. Kegan

Treasurer
Tom Lilley

Executive Director
Phyllis T. Piotrow

Directors
Barry Bingham, Sr.
Norman E. Borlaug
Harold W. Bostrom
Ellsworth Bunker
Yvonne Brathwaite Burke
Cass Canfield
Mrs. Otis Chandler
Philander P. Claxton, Jr.
John Conyers, Jr.
William H. Draper III
Angier Biddle Duke
Henry H. Fowler
Lincoln Gordon
Mrs. John L. Loeb
Edwin M. Martin
James S. McDonnell
George C. McGhee
Mrs. Edward P. Morgan
Stewart R. Mott
Robert R. Nathan
Claes Nobel
H. Bruce Palmer
Russell W. Peterson
Rodney Shaw
Frank A. Southard, Jr.
Robert Taft, Jr.
Maxwell D. Taylor
Mrs. Carll Tucker, Jr.
Charles E. Wampler
William C. Westmoreland

The Draper World Population Fund

Honorary Sponsors

S. O. Adebo
Robert O. Anderson
George W. Ball
Begum Nusrat Ispahani Bhutto
Jonathan B. Bingham
Norman E. Borlaug
Ellsworth Bunker
Lord Caradon
Antonio Carrillo Flores
W. Sterling Cary
Mrs. Otis Chandler
Alan Cranston
Michael E. DeBakey
Francisco de Sola
C. Douglas Dillon
Toshio Doko
William H. Draper III
Erhard Eppler
Henry H. Fowler
Donald M. Fraser
Orville L. Freeman
J. William Fulbright
John Kenneth Galbraith
Richard N. Gardner
Philip Handler
H.R.H. Prince Bernhard
John A. Hannah
Mrs. Andrew Heiskell
Walter W. Heller
Paul-Marc Henry
Felipe Herrera
Ernest F. Hollings
Hubert H. Humphrey
Daniel K. Inouye
Grayson Kirk
Nobusuke Kishi
Mrs. John L. Loeb
Yoshinori Maeda
Sicco L. Mansholt
Sayed Ahmed Marei
William McChesney Martin, Jr.
Spark Matsunaga
George C. McGhee
George McGovern
Robert S. McNamara
Gunnar Myrdal
Antonio Ortiz Mena
Richard L. Ottinger
Bob Packwood
Aurelio Peccei
Charles H. Percy
James A. Perkins
H.R.H. Prince Philip
Russell W. Peterson
Galo Plaza
Elliot L. Richardson
Paul G. Rogers
William P. Rogers
Carlos P. Romulo
William D. Ruckelshaus
Peter Scott
Binay R. Sen
Joseph E. Slater
C. P. Snow
John Sparkman
Maurice F. Strong
Joseph Sunnen
James W. Symington
Robert Taft, Jr.
Naval H. Tata
Maxwell D. Taylor
Jan Tinbergen
Marietta Tree
Alice Tully
Joseph D. Tydings
Victor H. Umbricht
Mrs. Theodore O. Wedel
Roy Wilkins
Willard Wirtz
Salvador Zubiran

Honorary Founder
Ryoichi Sasakawa

Executive Committee
Mrs. Angier Biddle Duke, Co-Chairman
William S. Gaud, Co-Chairman
Rufus S. Day, Jr.
J. George Harrar
Mrs. Albert D. Lasker
Tom Lilley
Stewart R. Mott
James W. Riddleberger
Robert B. Wallace
Mrs. Richardson White, Jr.

Address

Suite 550
1120 19th Street, N.W.
Washington, D.C. 20036
Telephone: 202-659-1833

Suite 808
30 West 54th Street
New York, N.Y. 10019
Telephone: 212-582-2220

POPULATION CRISIS COMMITTEE
DRAPER WORLD POPULATION FUND
1120 19th Street, N.W.
Washington, D. C. 20036